ST

UNITED NATIONS

Secretariat

ST/IC/1997/32
28 May 1997

INFORMATION CIRCULAR

To: Members of the staff at Headquarters

From: The Controller

Subject: RENEWAL OF THE HEADQUARTERS MEDICAL AND DENTAL INSURANCE PLANS EFFECTIVE 1 JULY 1997, AND ANNUAL ENROLMENT CAMPAIGN, 2-6 JUNE 1997*

General

1. The purpose of the present circular, which supersedes information circular ST/IC/1996/33, dated 24 May 1996, is to announce:

[a] Changes in the premium and contribution rates which will come into effect on 1 July 1997 (see p. 2);

[b] The introduction, with effect from 1 July 1997, of the Aetna "Open Choice" plan. This plan is an expansion of the current traditional Aetna indemnity plan, combining the full benefits of the current Aetna plan along with the advantages of a network of preferred providers, and has been outlined in information circular ST/IC/1997/29, dated 19 May 1997. New Aetna identification cards will be issued. Staff members enrolled in the current Aetna plan will automatically be enrolled in the new Aetna Open Choice plan unless they decide to switch to one of the other Headquarters health insurance plans during the forthcoming health insurance enrolment campaign to be held from 2 to 6 June 1997;

[c] New benefits which include reimbursement for acupuncture treatment for the relief of chronic pain under both the new Aetna and the Blue Cross BlueChoice plans. In addition, under the Aetna Open Choice plan, additional new benefits include a vision care programme, routine physical check-ups and the elimination of any age limits for mammography.

2. Annexes I to VIII to the present circular set out plan outlines and benefit summaries. These annexes are listed in paragraph 23.

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* Personnel Manual index No. 6170.

HEADQUARTERS MEDICAL AND DENTAL INSURANCE
SCHEDULE OF MONTHLY PREMIUMS a/ AND CONTRIBUTION RATES b/
(Effective 1 July 1997)

Type of coverage		Aetna Open Choice	Blue Cross BlueChoice	HIP/HMO	Kaiser/HMO	GHI Dental with medical plan	GHI Dental alone
Staff member only							
Premium rate	($)	319.34	204.34	174.66	189.82	23.14	23.14
Contribution rate	(%)	2.83	1.82	1.57	1.68	0.20	0.30
Staff member and one child							
Premium rate	($)	614.51	407.67	345.78	379.64	55.15	55.15
Contribution rate	(%)	4.78	3.22	2.67	2.97	0.40	0.60
Staff member and spouse							
Premium rate	($)	614.51	407.67	345.78	379.64	55.15	55.15
Contribution rate	(%)	4.78	3.22	2.67	2.97	0.40	0.60
Staff member and two or more eligible family members							
Premium rate	($)	775.05	591.89	509.76	512.52	115.59	115.59
Contribution rate	(%)	5.37	4.13	3.57	3.52	0.79	1.19

a/ The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see below) by the related percentage of salary.

b/ "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. Actual contributions are capped at 85 per cent of the corresponding premium.

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Annual enrolment campaign

3. The annual enrolment campaign at Headquarters will be held from 2 to 6 June 1997 at the offices of the Insurance, Claims and Compensation Section (ICCS) of the Office of Programme Planning, Budget and Accounts, room S-2765, between the hours of 10 a.m. and 5 p.m. STAFF MEMBERS AT HEADQUARTERS MUST COME IN PERSON TO THE INSURANCE, CLAIMS AND COMPENSATION SECTION OFFICE TO COMPLETE THE APPLICATION FORM AND OTHER FORMS AS NECESSARY. The staff of the Insurance, Claims and Compensation Section will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff. In addition, representatives of the insurance companies will be on hand on 2 to 4 June, and Aetna on 5 and 6 June also, to provide information about the various insurance plans offered. The insurance company desks will be located in the staff activities area near the Secretariat cafeteria entrance.

4. **Staff members are reminded that, except as provided in paragraph 12, this will be the ONLY opportunity until June 1998 to enrol in the United Nations medical and dental insurance plans.** This is also an opportunity to review current medical insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans, as may be necessary or desirable. Staff members who are satisfied with their coverage do not need to take any action at this time.

5. The medical and dental plans being offered during the June campaign and the pages on which plan outlines may be found are as follows:

[a] Aetna Open Choice (p. 11);

[b] Blue Cross BlueChoice (p. 27);

[c] Health Insurance Plan of Greater New York, Health Maintenance Organization (HIP/HMO) (p. 36);

[d] Kaiser Foundation Health Plan of the Northeast, Health Maintenance Organization (Kaiser/HMO) (p. 39);

[e] Group Health Incorporated Dental Plan (GHI) (p. 42).

6. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 1997. **A change in enrolment between the Aetna and Blue Cross plans will oblige the participant to meet the annual out-of-network deductible in the new plan.**

Eligibility for enrolment

7. All staff members holding appointments of three months or longer (or six months or longer for dental coverage) under the 100 series of the Staff Rules whose duty station is New York and who are not enrolled in a Headquarters medical/dental insurance plan may enrol during this annual campaign. Medical insurance provisions pertaining to technical assistance project personnel are set out under Staff

Rule 206.4. Staff members holding appointments of limited duration under the 300 series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in line with the relevant provisions of administrative instruction ST/AI/395, dated 2 June 1994. Currently enrolled staff members may take the opportunity of the annual enrolment campaign to review their coverage and change from one plan to another, or change their coverage in respect of members of their family. The medical scheme applicable to staff holding appointments of less than three months under the 100 series of the Staff Rules or who hold short-term appointments under the 300 series of the Staff Rules is described in information circular ST/IC/86/44 of 15 September 1986.

8. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. Eligible family members may also be enrolled at this time, provided that evidence of the status (Personnel Action form) of such family members is presented to the Insurance, Claims and Compensation Section. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of their children and/or inclusion of those newly eligible or not covered at present.

9. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not engaged in full-time employment; disabled children may be eligible for continued coverage after age 25. Complete information regarding these provisions can be found in information circular ST/IC/86/72, entitled "Age limitation on the participation of dependent children in United Nations health insurance schemes".

10. Staff members, particularly those who have no coverage under a United Nations plan or through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members, especially since the high cost of medical care could result in financial hardship for individuals who fall ill and/or are injured and have no such coverage.

11. **In the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member.** It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance (ASHI) benefits following separation from service.

Enrolment between annual campaigns

12. Between annual campaigns, staff members and their family members may be allowed to enrol in the Headquarters medical and dental insurance plans ONLY if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

[a] In respect of medical insurance coverage, upon receipt of an initial appointment of at least three months' duration at Headquarters under the 100 or 300 series of the Staff Rules or upon appointment under the 200 series of the Staff Rules;

[b] In respect of dental insurance coverage, upon receipt of an initial appointment of at least six months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

[c] Upon transfer to Headquarters from another duty station;

[d] Upon return from special leave without pay, but only under the health scheme in which insured prior to taking leave (see para. 15 below);

[e] Upon assignment to a mission, under certain conditions (see para. 16 below); and/or

[f] Upon marriage, birth or legal adoption of a child for coverage of the related family member;

[g] Upon the provision of evidence that the staff member was on mission or annual or sick leave for the entire duration of the annual campaign, staff members may enrol within 31 days of their return to Headquarters.

13. In all the cases cited in paragraph 12 above, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance, Claims and Compensation Section within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and inquiries with regard to changes relating to such events occurring between campaigns should be directed to the Insurance Section as follows:

Insurance, Claims and Compensation Section
Office of Programme Planning, Budget and Accounts
Room S-2765
United Nations Headquarters
New York, NY 10017

14. **Applications between enrolment campaigns based on any other circumstances or not received within 31 days of the event giving rise to eligibility will not be receivable by the Insurance, Claims and Compensation Section and will be returned.** In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment campaigns, the staff member must wait until the next campaign to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage are urged to consider enrolling in a United Nations scheme during the present campaign.

Staff on special leave without pay

15. Staff members who are granted special leave without pay are reminded that they may retain coverage for medical and dental insurance during such periods or may elect to discontinue such coverage for the period of the special leave:

[a] Insurance coverage maintained during special leave without pay. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance, Claims and Compensation Section MUST be informed directly by the staff member of his or her intention at least one month in advance of the commencement of the special leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Insurance, Claims and Compensation Section will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

[b] Insurance dropped while on special leave without pay. Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, no action is required upon commencement of the special leave;

[c] Re-enrolment upon return to duty following special leave without pay. Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Insurance, Claims and Compensation Section upon return to duty, in person if at Headquarters, or in writing if away from Headquarters. This must be done within 31 DAYS OF RETURN TO DUTY. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan(s) until the next annual enrolment campaign in the month of June.

Staff members assigned on mission

16. In view of the large number of staff members who go on mission assignment, a special medical/dental plan enrolment opportunity is extended to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

[a] Staff members who at present are NOT enrolled in any United Nations health insurance plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in a health insurance plan in these circumstances must be completed PRIOR to the departure of the staff member on mission assignment;

[b] Staff members assigned to a mission who are enrolled in either HIP or Kaiser, two plans which do not offer full services at locations away from Headquarters, may switch to either Aetna or BlueChoice. These two plans provide benefits on a worldwide basis. Enrolment in the Aetna or BlueChoice plans under this provision must be completed PRIOR to the departure of the staff member on mission assignment;

[c] Staff members who, at the time of commencement of the mission assignment, do not have GHI Dental coverage but who are already enrolled, together with eligible family members, in Aetna or BlueChoice, may enrol themselves and family members covered under their medical insurance plan in the dental plan. Such enrolment must be completed PRIOR to the departure of the staff member on mission assignment;

[d] Staff members who elect to enrol in a health insurance plan in the circumstances provided under subparagraphs [a] to [c] above forego the right to make any further change during the annual enrolment campaign taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment campaign of the following year;

[e] Staff members who are already enrolled in Aetna or BlueChoice at the time of the mission assignment must retain their existing coverage until the next annual enrolment campaign;

[f] Staff members who will be on mission assignment for six months or more AND WHO WILL NOT HAVE ELIGIBLE COVERED FAMILY MEMBERS RESIDING IN THE UNITED STATES for the duration of the mission assignment may opt for coverage under the Van Breda Medical, Hospital and Dental Insurance plan for staff overseas. Details of this plan are available in the offices of the Insurance, Claims and Compensation Section, room S-2765;

[g] Staff members returning to Headquarters from mission assignment, other than those who qualified and opted for the Van Breda plan, may not change their insurance coverage until the next annual enrolment campaign. **Staff members who switched to the Van Breda plan, as provided under subparagraph [f] above, must revert, upon return to Headquarters, to the insurance plan that they had prior to the mission assignment, at least until the next annual enrolment campaign.** It is essential that such staff members advise the Insurance, Claims and Compensation Section within 31 days of their return to Headquarters. **Failure to re-enrol in the prior Headquarters plan within 31 days of return to duty from mission assignment will result in suspension of health insurance coverage.**

IN ALL CASES, STAFF MEMBERS GOING ON MISSION ASSIGNMENT WHO WISH TO ENROL IN A HEALTH INSURANCE PLAN OR CHANGE THEIR PRESENT COVERAGE, AS PROVIDED ABOVE, MUST PRESENT EVIDENCE TO THE INSURANCE, CLAIMS AND COMPENSATION SECTION OF THE MISSION ASSIGNMENT AND ITS DURATION.

Cessation of coverage of family members

17. The Insurance, Claims and Compensation Section should be notified immediately of changes in the staff member's family that result in a family member ceasing to be eligible, e.g., a spouse upon divorce or a child reaching the end of the calendar year in which the age of 25 years is attained, marrying or taking up full-time employment. The responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") RESTS WITH THE STAFF MEMBER. Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other

reason may do so at any time, although this is strongly discouraged. Such removals of family members from coverage should be communicated to the Insurance, Claims and Compensation Section directly. It is in the interest of staff members to notify the Insurance, Claims and Compensation Section promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance, Claims and Compensation Section.

After-service health insurance

18. Staff members are reminded that, among the eligibility requirements for ASHI coverage, the ASHI applicant must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized ASHI participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the ASHI staff member at the time of separation are eligible for continued coverage under the programme. After-service participants are reminded that the restriction set out in paragraph 4 above, to the effect that staff members may switch from one insurance plan to another only during the period of the annual enrolment campaign, does not apply fully to them. Full details on the eligibility requirements and administrative procedures relating to ASHI coverage are set out in administrative instruction ST/AI/394, dated 19 May 1994.

Conversion privilege

19. Participants who cease employment with the United Nations and are not eligible for after-service benefits may arrange for medical coverage under an individual contract. This provision applies to all plans currently offered. The conversion privilege, which is part of the United Nations group contracts with the respective insurance companies, means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. THE CONVERSION PRIVILEGE, HOWEVER, DOES NOT MEAN THAT THE SAME INSURANCE PREMIUM RATES OR SCHEDULE OF BENEFITS IN EFFECT FOR THE UNITED NATIONS GROUP POLICY WILL BE OFFERED IN RESPECT OF INDIVIDUAL INSURANCE CONTRACTS. It should be noted, moreover, that the conversion privilege may be exercised only for separating staff who continue to reside in the United States as the insurers cannot write individual policies for persons residing abroad. In all cases, the conversion privilege must be exercised WITHIN 31 DAYS OF THE DATE OF SEPARATION. Details concerning conversion to individual policies under Aetna and Blue Cross BlueChoice may be obtained from the Insurance, Claims and Compensation Section, room S-2765. Details concerning conversion to individual policies under HIP, Kaiser and GHI Dental should be obtained from those companies directly.

Where to address claims and benefit inquiries

20. Although the staff of the Insurance, Claims and Compensation Section is available to assist staff members in administrative matters concerning participation

in the various Headquarters insurance plans and problematic claims issues, claims questions should always be taken up in the first instance directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex VIII to the present circular.

21. Staff members are reminded that the plan descriptions set out in annexes I to V constitute summaries of the benefits available under the respective plans. Every care has been taken to ensure that the plan summaries are as comprehensive as possible. However, in the event of a claim dispute with any of the insurance carriers concerned, the resolution of such dispute will be guided by the terms and conditions of the policy contract in question and the final decision will rest with the insurance carrier concerned, not with the United Nations. The contracts with the insurance carriers are available for review by subscribers, as may be necessary, by appointment at the offices of the Insurance, Claims and Compensation Section, room S-2765.

Headquarters health insurance plans: outlines and summaries of benefits

How plans are costed

22. The United Nations policies with Aetna, Blue Cross and GHI are "experience-rated". This means that the premium cost each year of the Aetna, BlueChoice and GHI Dental plans is based on the level of claims incurred in the prior year and expected rates of utilization and medical cost inflation for the renewal period. In effect, the costs of these plans (claims incurred plus administrative expenses) are borne collectively by participants in these schemes. In a year following a period of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been relatively moderate, the premium increase in the subsequent year will be correspondingly moderate. The two health maintenance organization (HMO) plans, HIP and Kaiser, are "community-rated". This means the premium costs are based on the combined experience of all employers participating in these schemes, not just the United Nations, and are approved by the relevant state insurance authorities. It should be emphasized, particularly with respect to the three experience-rated plans, that prudent utilization by all participants concerned will have the effect of moderating premium costs for the benefit of all.

Plan outlines and benefit summaries

23. Outlines of the health insurance plans offered as well as summaries of benefits of each plan are set out in the following annexes:

		Page
I.	Aetna Open Choice	11
II.	Blue Cross BlueChoice	27
III.	HIP/HMO	36
IV.	Kaiser/HMO	39
V.	GHI Dental	42

In addition, information regarding the World Access (formerly Access America) emergency facility for Aetna and BlueChoice subscribers, a listing of participating Aetna and BlueChoice pharmacies as well as a listing of insurance carrier addresses and telephone numbers are set out in the following annexes:

VI. World Access 48
VII. Aetna and BlueChoice, participating pharmacies 49
VIII. Insurance carrier addresses and telephone numbers for claims and benefit inquiries 50

24. In addition to the information contained in the various annexes to the present circular, listings of participating providers of the GHI Dental plan, Blue Cross affiliated hospitals overseas and participating pharmacies under both the Blue Cross and Aetna programmes are available at the offices of the Insurance, Claims and Compensation Section, room S-2765.

Annex I

AETNA "OPEN CHOICE" PLAN

Plan outline

The Aetna Open Choice health benefits plan (Aetna) offers worldwide coverage for hospitalization and surgical, medical and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or non-network provider.

Aetna Open Choice is a dual-track plan that offers all the benefits of the traditional Aetna indemnity plan plus the option of a preferred provider organization (PPO) network of physicians and other medical providers nationwide. This means that participants can choose, if they wish, to go to a doctor who is in-network and pay only $10 per visit or treatment without any further need to file a claim with Aetna. Alternatively, participants may opt to receive treatment from any physician not in the network and be reimbursed by Aetna in the usual way, subject to the annual deductible and the normal co-insurance. A comprehensive summary of the plan, both the in-network and the non-network (traditional indemnity) benefits are set out in outline form commencing on page 13.

Under the non-network (traditional) track of the new Aetna plan, when a participant has met the annual deductible of $125 per individual and $375 per family and a further $1,000 per covered individual in co-insurance (20 per cent of $5,000 of recognized expenses), Aetna will reimburse all further claims incurred in the year, subject to the provision that they be "reasonable and customary", at 100 per cent. The deductible and co-insurance requirement must be met each calendar year. There is no lifetime reimbursement limit under the Aetna plan. When a participant is treated by a network physician, paying the fixed $10 co-payment for each visit, it is important to note that those $10 amounts do not count towards meeting the $1,000 out-of-pocket expense limit referred to above. This is so because, under the in-network track of the plan, medical expenses are already considered to have been paid at 100 per cent to the network provider after the participant has met the fixed $10 co-pay.

Aetna identification cards, provider directories and plan description book

All subscribers to the current Aetna plan will be automatically enrolled at the appropriate level of coverage in the new Aetna Open Choice plan. Unless a current Aetna subscriber wishes to take the opportunity of the enrolment campaign to switch to Blue Cross BlueChoice, HIP or Kaiser, no enrolment action is required. Of course, if a staff member currently enrolled in the Aetna plan wishes to add a dependant to his or her coverage under the new Aetna Open Choice plan after 1 July 1997, then appropriate application must be made during the enrolment campaign period.

EVERY PARTICIPANT IN THE AETNA OPEN CHOICE PLAN WILL RECEIVE A NEW IDENTIFICATION CARD (TWO COPIES). THE AETNA CARD IS VALID FOR BOTH HOSPITAL AND MEDICAL SERVICES AS WELL AS FOR THE DISCOUNT PRESCRIPTION DRUG PLAN. ARRANGEMENTS

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HAVE BEEN MADE BY AETNA FOR BOTH THE PROVIDER DIRECTORY AND THE AETNA OPEN CHOICE PLAN DESCRIPTION BOOK TO BE MAILED TO PARTICIPANTS AT THEIR PLACE OF RESIDENCE. ENCLOSED IN THE ENVELOPE CONTAINING THE NEW AETNA IDENTIFICATION CARD WILL BE A PRE-ADDRESSED POSTCARD TO BE COMPLETED AND RETURNED TO AETNA. ONLY BY RETURNING THE POSTCARD TO AETNA WILL OPEN CHOICE SUBSCRIBERS RECEIVE THE PROVIDER DIRECTORY AND PLAN DESCRIPTION BOOK, AS COPIES OF THE DIRECTORY AND PLAN DESCRIPTION WILL NOT BE HELD IN STOCK IN THE UNITED NATIONS.

Premium

There will be no increase in the total monthly premium of the Aetna plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1997. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

While the package of benefits under the Aetna Open Choice plan is itemized in the plan summary (pp. 13-20), participants should take note of certain new benefits not previously available in the Aetna plan. Apart from the availability of the nationwide preferred provider network, benefits under the new plan include routine physical examinations, mammography benefits without any age limit or requirement of referral by a physician, coverage of acupuncture treatment by a medical doctor or licensed acupuncturist for the treatment of chronic pain conditions up to a maximum benefit of $1,000 per calendar year, and a discounted vision care programme (known as Vision One) which can be utilized as frequently as desired. In addition, under the Aetna Open Choice plan, there is no obligation on the part of the participant to pre-certify a hospital admission with the insurer and, therefore, there are no penalties in this respect. However, the provisions relating to the Focused Psychiatric Review (FPR) programme, which has been in place for several years and remains unchanged, do require pre-certification of admission for the treatment of mental and nervous disorders or substance abuse conditions (pp. 23-24).

Aetna claims

The address to which Aetna claim forms should be sent is as follows:

Aetna Life Insurance Company
Unit 73
3541 Winchester Road
Allentown, PA 18195-0501

Summary of benefits under the Aetna Open Choice plan and the current traditional Aetna plan

Plan features	Preferred benefits (In-network)	Non-preferred benefits (Out-of-network)	Current Basic Hospital/ Major Medical Plan
Plan deductible	$0 Individual $0 Family	$125 Individual $375 Family	$125 Individual $375 Family
Co-insurance limit	$1,000 Individual $3,000 Family		$1,000 Individual $3,000 Family
Lifetime maximum	Unlimited	Unlimited	Unlimited
Physician services (except Mental health/Alc/Drug)			
Office visits (non-surgical)	100% after $10 co-payment	80% after deductible	80% after deductible
Specialist (office visits)	100% after $10 co-payment	80% after deductible	80% after deductible
Routine physicals/ immunizations Well-baby care to age 7; 1 exam every 24 months for ages 7 to 19; including immunizations	100%	100%	100%
Routine physicals/ immunizations Children age 19+ and adults: 1 routine exam every 24 months. (One routine exam annually for members age 65 and older); including immunizations.	100% after $10 co-payment	80% after deductible	Not covered
Routine mammography (no age limit)	100%	80% after deductible; 100% if performed on an in-patient or in the outpatient department of a hospital	80% after deductible; 100% if performed on an in-patient or in the outpatient department of a hospital

Plan features	Preferred benefits (In-network)	Non-preferred benefits (Out-of-network)	Current Basic Hospital/ Major Medical Plan
Routine ob/gyn exam (All routine exam per calendar year; including 1 pap smear and related fees)	100% after $10 co-payment	80% after deductible	80% after deductible
Surgery	100%	80% after deductible	80% after deductible
Physician in-hospital services	100%	80% after deductible	80% after deductible
Allergy testing and treatment (given by physician)	100% after $10 co-payment	80% after deductible	80% after deductible
Allergy injections (not given by physician)	100%	80% after deductible	80% after deductible
Other physician services	100%	80% after deductible	80% after deductible
Diagnostic X-ray and laboratory (other than physician's office)	100%	80% after deductible	80% after deductible
Hospital services			
In-patient coverage	100%	100%	100%
Outpatient coverage	100%	100%	100%
Emergency room (based on symptoms)	100% Covers sickness within 12 hours' onset; surgery, accident within 72 hours	100% Covers sickness within 12 hours' onset; surgery, accident within 72 hours	100% Covers sickness within 12 hours' onset; surgery, accident within 72 hours
Non-emergency use of the emergency room (examples of conditions: skin rash, earache, bronchitis, etc.)	80%	80% after deductible	80% after deductible

Plan features	Preferred benefits (In-network)	Non-preferred benefits (Out-of-network)	Current Basic Hospital/ Major Medical Plan
Acupuncture* (for chronic pain treatments only, services must be rendered by a medical doctor or licensed acupuncturist)	100% after $10 co-payment up to a maximum benefit of $1,000	80% after deductible up to a maximum benefit of $1,000	Not covered
Spinal manipulation*	100% after $10 co-payment up to a maximum benefit of $1,000	80% after deductible up to a maximum benefit of $1,000	80% after deductible up to a maximum benefit of $1,000
Mental health services**			
In-patient coverage	100%	100% after deductible	100% for first 30 days; additional 30 days at 80% after deductible
	Maximum 90 days per calendar year***	Maximum 90 days per calendar year***	Maximum 60 days per calendar year
Outpatient coverage	100% up to maximum benefit of $3,216 per calendar year***	80% after deductible up to maximum benefit of $3,216 per calendar year*** $134 per visit	80% after deductible up to maximum benefit of $3,216 per calendar year $134 per visit
Crisis intervention	100% up to 3 visits per calendar year***	80% after deductible up to 3 visits per calendar year***	80% after deductible up to 3 visits per calendar year

* Preferred and non-preferred benefits are combined for a maximum of $1,000 per calendar year.

** See Focused Psychiatric Review (p. 20)

*** Maxima are for the calendar year whether preferred or non-preferred, or a combination of the two.

Plan features	Preferred benefits (In-network)	Non-preferred benefits (Out-of-network)	Current Basic Hospital/ Major Medical Plan
Alcohol/drug abuse*			
In-patient coverage	100%	100% after deductible	100% for first 30 days; additional 30 days at 80% after deductible
Maximum	60 days per calendar year**	60 days per calendar year**	60 days per calendar year
Lifetime maximum	2 confinements**	2 confinements**	2 confinements
Outpatient coverage	100% Up to 60 visits per calendar year** (includes 20 visits* for counselling)	80% after deductible Up to 60 visits per calendar year** (includes 20 visits** for counselling)	80% after deductible Up to 60 visits per calendar year (includes 20 visits for counselling)
Maternity (coverage includes voluntary sterilization and voluntary abortion)	100% after $10 co-payment; 100% voluntary sterilization if performed in-patient or in the outpatient department of a hospital	80% after deductible; 100% voluntary sterilization if performed in-patient or in the outpatient department of a hospital	80% after deductible; 100% voluntary sterilization if performed in-patient or in the outpatient department of a hospital
Prescription drug	100% after 15% co-payment; up to 30-day supply at participating pharmacies; co-payment maximum $15	80% after deductible	In-network: 100% after 15% co-payment; up to 30-day supply at participating pharmacies; co-payment maximum $15

*** See Focused Psychiatric Review (FPR) (p. 20)**

**** Maxima are for the calendar year whether preferred or non-preferred, or a combination of the two.**

Plan features	Preferred benefits (In-network)	Non-preferred benefits (Out-of-network)	Current Basic Hospital/ Major Medical Plan
	100% after $10 co-payment; up to 90-day supply from participating Mail Order vendor; when brand name is requested, member must pay co-payment plus difference between brand and generic price unless "DAW" is written on prescription		100% after $10 co-payment; up to 90-day supply from participating Mail Order vendor; when brand name is requested, member must pay co-payment plus difference between brand and generic price unless "DAW" is written on prescription
			Out-of-network: 80% after deductible
OTHER BENEFITS **Skilled nursing facility**	100% up to 365 days per calendar year		100% up to 365 days per calendar year
Home health care	100% 320 visits per calendar year (no prior confinement required)	100% for first 200 visits; 80% after deductible for additional 120 visits per calendar year (no prior confinement required)	If within 7 days of discharge 100% for first 200 visits; 80% after deductible for additional 120 visits per calendar year. If no prior confinement, 80% after deductible for 80 visits per calendar year

Plan features	Preferred benefits (In-network)	Non-preferred benefits (Out-of-network)	Current Basic Hospital/ Major Medical Plan
Ambulance*	100%		100%
Private-duty nursing (restricted benefit on an in-patient basis)	100% up to 70 eight-hour shifts per calendar year	80% after deductible up to 70 eight-hour shifts per calendar year	80% after deductible up to 70 eight-hour shifts per calendar year
Hospice care In-patient and outpatient coverage	100% up to 210 days for both in-patient and outpatient services		100% up to 210 days for both in-patient and outpatient services
Bereavement counselling	100% up to 5 visits		100% up to 5 visits
Short-term rehabilitation Physical, occupational therapy	100%	80% after deductible	80% after deductible
Speech therapy	80% deductible does not apply**		
Hearing aid Hearing device*	80% deductible does not apply Maximum $750, 1 hearing aid per ear every 3 years		80% after deductible Maximum $750, 1 hearing aid per ear every 3 years

* There are no preferred (or in-network) providers of these services at the present time.

** When services are rendered by a participating provider, 100 per cent reimbursement applies.

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Plan features	Preferred benefits (In-network)	Non-preferred benefits (Out-of-network)	Current Basic Hospital/ Major Medical Plan
Evaluation and audiometric exam	100% after $10 co-payment	Maximum $100, 1 exam every 3 years, must be examined by otolaryngologist or state-certified audiologist	Maximum $100, 1 exam every 3 years, must be examined by otolaryngologist or state-certified audiologist
Outpatient diabetic self-management education programmes	80% deductible does not apply*		Payable as any other covered expense
Durable medical equipment	80% deductible does not apply**		80% after deductible
Vision care Optical lenses (including contact lenses)	80% deductible does not apply; maximum $60 for any 2 lenses in a 24-month period		80% after deductible. Maximum $60 for any 2 lenses in a 24-month period
Vision one programme	Savings up to 65% on frames; up to 50% on lenses; about 20% on contacts at participating Cole Vision centres. Refer to separate handout for details.		None
In-patient pre-certification	Provider-initiated	Not required	None

* If services are rendered in a hospital, 100 per cent reimbursement applies with no co-payment. If rendered in an in-network doctor's office, 100 per cent reimbursement with $10 co-payment applies.

** If services are rendered by a participating provider or within a hospital setting, 100 per cent reimbursement applies with no co-payment.

Plan features	Preferred benefits (In-network)	Non-preferred benefits (Out-of-network)	Current Basic Hospital/ Major Medical Plan
Focused psychiatric review*			
Penalty for failure to pre-certify in-patient psychiatric treatment	None	$100 penalty; applies per occurrence	$400 penalty; applies per occurrence
Second surgical opinion	Not required, however covered at 100% after $10 co-payment	Not required, however covered at 100% after deductible	100% after deductible
Claim submission	Provider-initiated	Member-initiated	Member-initiated

* In-patient mental health services, including alcohol/substance abuse treatment, are provided under the Focused Psychiatric Review (FPR) programme. For in-patient confinements, pre-certification is required. For in-network services, the network provider is responsible for pre-certification. For non-network services, either the physician or the staff member must pre-certify the confinement.

New "Vision One" eyecare discount programme

Effective 1 July 1997, a new vision care discount programme will be offered by Aetna to all subscribers to the Aetna plan. **The new Vision One programme is an addition to, not a substitute for, the existing optical lens benefit which will be continued as before.**

The Vision One programme offers subscribers and covered family members immediate discounts on eyecare needs including frames, lenses and contact lenses. The programme is available at over 2,500 locations nationwide including the optical centres in national retail outlets such as Sears, JC Penney and Montgomery Ward and many of the Pearle Vision Centers as well as selected independent providers/offices. To obtain the discounts available under this programme, it is only necessary to show the provider the Aetna identification card at the time of the visit. The provider will apply the discounts to any purchases made and will accept valid prescriptions from any licensed optometrist or opthalmologist. The Vision One programme may be used as often as desired. As it is simply a discount programme, claim forms are not required. For more details and outlet locations, call Vision One at (800) 793-8616, weekdays from 9:00 a.m. to 9:00 p.m. and Saturdays from 9:00 a.m. to 5:00 p.m. A schedule of costs and typical savings under the programme is set out below.

Benefits	Vision One cost	Typical savings
Frames		
Priced up to $60.00 retail	$20.00	65.0%
Priced from $61.00 to $80.00 retail	$30.00	60.0%
Priced from $81.00 to $100.00 retail	$40.00	60.0%
Priced from $101.00 to $200.00 retail	50.0%	50.0%
Lenses - per pair (uncoated plastic)		
Single vision	$30.00	50.0%
Bifocal	$50.00	45.0%
Trifocal	$60.00	45.0%
Lenticular	$100.00	50.0%
Lens options - per pair (add to lens prices above)		
Standard-Progressive (no line bifocals)	$50.00	25.0%
Polycarbonate	$30.00	45.0%
Scratch resistant coating	$12.00	40.0%
Ultraviolet coating	$12.00	40.0%
Solid or gradient tint	$ 8.00	45.0%
Glass	$15.00	60.0%
Photochromic	$30.00	55.0%
Anti-reflective coating	$35.00	30.0%
Transitions	$55.00	35.0%

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Benefits	Vision One cost	Typical savings

Eye examinations (by licensed independent doctors of optometry)

Spectacle - $5.00 off normal fee
Contact - $10.00 off normal fee

Contact lenses (two ways to save on contact lenses)

1. Visit the more than 2,500 locations nationwide and save 20 per cent discount from regular retail prices.

2. Use the Vision One Contact Lens Replacement Programme for additional savings and convenience.

   Call (800) 391-5367 for this service.

Dispensing fee

The fee for fitting and dispensing (including unlimited eyeglass adjustments) is only $8.00. There is no dispensing fee for contact lenses.

New acupuncture benefits

With effect from 1 July 1997, the Aetna Open Choice plan will provide benefits for acupuncture treatment rendered by a medical doctor or licensed acupuncturist, up to a maximum benefit of $1,000 per calendar year. While this benefit will be described in the plan description book to be made available to all participants, the scope of the benefit may be summarized as follows:

Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension headache
- Migraine headache
- Psychalgia
- Neuralgia
- Backache
- Lumbago
- Muscle spasm
- Bursitis

Acupuncture treatment in lieu of anaesthesia has been recognized as a reimbursable procedure by Aetna under the traditional plan. This benefit, as all other benefits under the traditional plan, will be maintained under Aetna Open Choice.

Mental and nervous and substance abuse benefits

A. In-patient benefits

All hospitalization for mental and nervous and substance abuse conditions is subject to the Focused Psychiatric Review (FPR) procedure. STAFF MEMBERS ARE ASSURED THAT THE FPR PROGRAMME IS CONDUCTED IN THE STRICTEST CONFIDENCE. The procedure is as follows:

1. Prior to a non-emergency hospital admission, Aetna must be informed of the intended admission. This is accomplished by placing a telephone call to a toll free Aetna number ((800) 424-1601). This call will be taken by a member of the Aetna FPR team. The telephone call may be placed by the subscriber himself or herself, the attending physician, a family member, or any other person acting for the patient to be hospitalized.

2. The initial information required by Aetna in order to pre-certify the admission includes the subscriber's identification number (payroll index number), the reason for the admission, the physician's name, address and telephone number, the hospital name, address and telephone number, and the scheduled admission date.

3. The FPR specialist then contacts the attending physician to review the information prior to certification of the admission. If the attending physician makes the original call to the 800 number, this step will be accomplished at that time. The FPR specialist certifies a certain number of in-patient days, if appropriate, and develops a plan of regular follow-up visits with the attending physician. Failure to pre-certify an in-patient admission for mental and nervous and substance abuse treatment will result in a $100 reduction of the benefit amount paid.

4. An emergency admission, which cannot be pre-certified before the confinement begins, must be called in to the Aetna FPR number within 48 hours of the emergency admission.

B. In-patient mental and nervous and substance abuse care

1. The full cost (semi-private accommodation) of 30 days of hospitalization for the treatment of mental and nervous disorders. Hospital confinements beyond 30 days are reimbursed subject to the normal deductible and co-insurance provisions.

2. The full cost (semi-private accommodation) of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation, limited to two 30-day benefit periods in a lifetime. Continuous confinement of up to 30 days beyond this 30-day limit is subject to the provision under paragraph 3 below.

3. Coverage for up to 30 days of hospitalization for substance-abuse (alcohol and/or drug) rehabilitation after the 30-day hospitalization benefit described in the paragraph above has been exhausted. This benefit is available twice in a lifetime and is applicable only as a continuation of each of the two 30-day hospitalization periods provided under paragraph 2 above.

C. Out-patient mental and nervous and substance abuse care

1. A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric social worker). The maximum recognized charge per visit for such treatment, $134, is reimbursable at 80 per cent, i.e., $107.20. The annual maximum will be $3,216 (30 visits x $107.20 = $3,216). Under this arrangement, the minimum number of covered visits per year will be 30. Visits beyond this number will be covered until the annual (calendar year) maximum of $3,216 has been reached. Provider fees exceeding the $134-per-visit rate or the $3,216 annual maximum will be borne by the participant. Co-payments made in respect of this benefit do not apply to the $1,000 annual co-payment maximum.

2. Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse.

Discount prescription drug programme (Aetna Pharmacy Management)

A. The Aetna Pharmacy Management (APM) prescription drug programme, along with its mail order affiliate, Walgreens Healthcare Plus, reimburses, at significant savings, the cost of prescription drugs obtained from participating pharmacies and from the Walgreens Healthcare Plus mail order facility.

1. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a specific brand be dispensed by indicating "Dispense as written" or "DAW", the generic equivalent drug will be provided by the pharmacist, and the discount off the AWP can be as high as 50 per cent, depending on the generic equivalent supplied. The discount for maintenance drugs obtained by mail through the Walgreens Healthcare Plus mail order facility will range from 18 per cent to as high as 50 per cent off AWP depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

2. The procedure under which prescription drugs are reimbursed through the Aetna Pharmacy Management Programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice along with the Aetna card (a listing of participating pharmacies in the New York metropolitan area may be found in annex VII). The pharmacist will fill the prescription for up to a 30-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) based upon the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

3. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through Walgreens Healthcare Plus mail order facility which will charge a fixed $10 co-insurance. The Walgreens order form supplied with the Aetna card should be utilized for ordering prescription drugs by mail. A new order form will be sent along with the filled prescription.

4. It should be noted that if a participant wishes to receive the brand-name drug even though the physician has not specifically prescribed the brand-name, the participating pharmacy will charge a participant 15 per cent of the cost of the brand-name drug, but not more than $15 per prescription. In cases in which a brand-name maintenance drug is ordered through the Walgreens mail order facility even though it has not been specifically prescribed, Walgreens will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

5. FOR RESIDENTS OF THE STATE OF NEW JERSEY, THE WALGREENS HEALTHCARE PLUS MAIL ORDER FACILITY IS NOW AVAILABLE.

B. As the Aetna prescription drug programme benefit is being administered separately by Aetna Pharmacy Management, the normal annual deductible under the Aetna plan will NOT be applied to prescription drugs. At the same time, however, prescription drug expenses will NOT count towards meeting the annual co-insurance limit of $1,000. Prescription drugs obtained outside the United States or within the United States but NOT through either the Aetna pharmacy network or the Walgreens mail order facility will be reimbursed in the normal manner through the submission of the standard claim form to the Aetna claims office in Allentown, Pennsylvania. In such cases, the normal annual deductible will have to be met before reimbursement is made, as well as the 20 per cent co-insurance, which will count towards meeting the annual limit of $1,000.

Other provisions

A. Special conditions apply to certain medical procedures for injury-related dental and cosmetic injury, for convalescent facility expenses and for treatment of temporo-mandibular joint syndrome (TMJ). Participants are advised to consult the Aetna claims office in advance of commencing treatment for these conditions.

B. Unlimited overall lifetime reimbursement benefits.

C. Certain expenses are not covered under the Aetna plan. These comprise expenses for services or supplies not deemed by Aetna as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Aetna as reimbursable under the plan, Aetna Member Services should be contacted at (800) 784-3991 prior to commencement of treatment. In addition, the Aetna policy contract document is on file in the offices of the Insurance, Claims and Compensation Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

D. If Aetna denies a claim in whole or in part, the subscriber will receive a written notice from Aetna. This notice will explain the reason for the denial and the appeal procedure. The request for review must be submitted in writing within 60 days of receipt of the notice. The subscriber should include the reasons for requesting the review and submit the request to the Aetna Allentown Claim Office. Aetna will review the claim and ordinarily notify the subscriber of its final decision within 60 days of receipt of the request. If special circumstances require an extension of time, notification will be given to that effect.

E. Subscribers should note that claims for reimbursement must be submitted to Aetna no later than two years from the date on which the medical expense was incurred. CLAIMS RECEIVED BY AETNA LATER THAN TWO YEARS AFTER THE DATE ON WHICH THE EXPENSE WAS INCURRED WILL NOT BE ELIGIBLE FOR REIMBURSEMENT.

Annex II

BLUE CROSS BLUECHOICE

Plan outline

The BlueChoice plan blends the features of a full indemnity (fee-for-service) plan with the advantages of an extensive network of participating providers covering most medical specialties. When treatment is rendered by a preferred (in-network) provider, the only charge to the participant is $10 (except for mental health/substance abuse treatment). On the other hand, the participant may equally be treated by a physician who is not a participating practitioner in the plan. Medical services rendered by non-participating (out-of-network) providers will be reimbursed subject to a deductible and 20 per cent co-insurance. The deductible and 20 per cent co-insurance requirement must be met each calendar year.

A network of physicians covering New York City and the New York metropolitan area participate in the BlueChoice plan and accept as payment a fee schedule arranged with Blue Cross. No deductible has to be met, but instead, the participant pays a $10 co-payment for each visit ($25 for mental health). If, however, a participating physician refers a patient to another provider who is non-participating, the deductible and 20 per cent co-insurance will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider (50 per cent co-insurance for mental health visits). A number of diagnostic laboratories are participating providers under the BlueChoice plan. When any laboratory tests are required, it is important that the physician be told to direct the tests to a participating laboratory, if possible. If this is done, the cost of the laboratory test will be paid in full and will not be subject to the normal deductible and co-insurance.

Blue Cross identification cards, provider directory and plan benefits book

New subscribers to the BlueChoice plan will receive two sets of identification cards (two cards in each set), one card evidencing membership in the plan itself and the other for the discount prescription drug plan. Enclosed in the envelope containing the new BlueChoice identification card will be a pre-addressed postcard for return to Blue Cross to be completed with the name and home address of each subscriber. By returning the postcard to Blue Cross, BlueChoice subscribers will receive the BlueChoice directory and benefits handbook. Copies of the directory and benefits handbook are not held in stock at the United Nations.

With effect from 1 July 1997, Blue Cross is issuing an updated BlueChoice provider directory and an updated benefits handbook. New subscribers to the BlueChoice plan will automatically receive the new editions of the directory and benefits handbook in the manner described above. Current subscribers may receive copies of the new directory and updated benefits handbook by sending a pre-addressed postcard to Blue Cross requesting the two documents. Blue Cross will mail the directory and handbook to the subscriber at the address indicated on the postcard. POSTCARDS FOR REQUESTING THE UPDATED BLUECHOICE PROVIDER DIRECTORY AND BENEFITS HANDBOOK ARE AVAILABLE IN THE OFFICES OF THE INSURANCE, CLAIMS AND COMPENSATION SECTION (ROOM S-2765).

New BlueChoice benefits handbook

Subscribers to the BlueChoice plan should be sure to request their copy of the new edition of the benefits handbook which updates and supersedes the benefits handbook issued in 1996. While in most respects the information set out in the new handbook is identical to that contained in the handbook issued last year, the new handbook does contain some revisions in the description of specific benefits. These revisions may be summarized as follows:

[a] An expansion of the description of the BlueChoice Utilization Management Programme (UMP);

[b] An expansion of the provisions relating to the resolution of appeals to Blue Cross in the event of a dispute regarding a claim;

[c] Additional information regarding maternity care benefits under the plan in respect of benefits for birthing centres and minimum length of stay in hospital following childbirth;

[d] A significant clarification of the benefit relating to emergency room treatment. Under the new provisions, Blue Cross defines an emergency as the sudden onset of a medical or behavioural condition which manifests itself by symptoms of such severity, including severe pain, that a prudent layperson with an average knowledge of medicine and health could reasonably expect that the absence of immediate medical attention would seriously jeopardize the health of the afflicted person.

[e] The new handbook updates information to reflect the new management of the Empire Pharmacy Management (EPM) programme in line with the new pharmacy identification cards which were distributed to BlueChoice participants in April.

Premiums

There will be a 5.5 per cent decrease in the total monthly premium of the BlueChoice plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1997. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

New acupuncture benefits

The BlueChoice plan provides benefits for acupuncture treatment rendered by a medical doctor (MD), a doctor of osteopathy (DO) or a doctor of dental surgery (DDS) provided that the practitioner is also a licensed acupuncturist.

Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension headache
- Migraine headache
- Psychalgia
- Neuralgia
- Backache
- Lumbago
- Muscle spasm
- Bursitis

Out-of-network provider utilization

Should the participant choose to be attended to by a non-participating (out-of-network) provider or be referred by an in-network physician to an out-of-network provider, BlueChoice will pay 80 per cent of the reasonable and customary charge after the participant has met a $150 deductible per individual/$450 per family. After $900 of unreimbursed reasonable and customary medical expenses have been paid by the participant in a given year, further reasonable and customary expenses will be reimbursed in full (100 per cent in lieu of 80 per cent).

BLUECHOICE® PPO BENEFITS SUMMARY	
PROGRAM BENEFITS	
LIFETIME BENEFIT MAXIMUM	Unlimited.
HOSPITAL BENEFITS	**MEMBER PAYS**
Inpatient [1] *(except behavioral health)* ■ Unlimited days — semiprivate room and board ■ Other hospital-provided services, facilities, supplies and equipment ■ Physical therapy, physical medicine or rehabilitation - up to 45 days per calendar year	$0
Outpatient ■ Ambulatory surgery [1] ■ Surgery [1] ■ Pre-surgical testing (must be performed within 7 days of admission) ■ Chemotherapy and radiation therapy ■ Mammography & cervical cancer screening	$0
Emergency Room/Facility *(initial visit)* ■ Accidental injury ■ Sudden & serious medical condition	$35 Copayment (waived if admitted within 24 hours)
Mental Health [2] ■ Up to 90 days per calendar year	$0
Alcohol/Substance Abuse [2] ■ Up to 7 days detox, up to 30 days rehab per year	$0
Outpatient Alcohol/Substance Abuse[1] ■ Up to 60 outpatient visits which include 20 family counseling visits per calendar year	$0
Home Health Care [2] ■ Up to 200 visits per calendar year	$0
Outpatient Kidney Dialysis ■ Home, hospital based, or free-standing facility treatment	$0
Skilled Nursing Facility [2] ■ Up to 365 days per calendar year	$0
Routine Nursery Care	$0
Hospice [2] ■ Up to 210 days per lifetime	$0

(1) Utilization Management Program must pre-approve, except for providers outside the United States.
(2) Behavioral health care management program must pre-approve, except for providers outside the United States.

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BLUECHOICE® PPO BENEFITS SUMMARY

PROGRAM BENEFITS	In-Network MEMBER PAYS	Out-of-Network MEMBER PAYS
ANNUAL DEDUCTIBLE	$0	$150 Individual $450 Family Maximum
COINSURANCE	$0	20%
COINSURANCE MAXIMUM (Coinsurance Stop-loss)	$0	$900 per Individual (Plus Deductible)
MEDICAL BENEFITS	**In-Network** MEMBER PAYS	**Out-of-Network** MEMBER PAYS
Office/Home Visits	$10 Copayment	Deductible and Coinsurance
Surgical Service	$0	Deductible and Coinsurance
Surgical Assistance	$0	Deductible and Coinsurance
Anesthesia	$0	Deductible and Coinsurance
Inpatient Visits	$0	Deductible and Coinsurance
Consultation Service ■ Office or home *(one per specialty)* ■ Hospital inpatient *(one per admission)*	$10 Copayment $0	Deductible and Coinsurance
Maternity Care	$0	Deductible and Coinsurance
Mammography Screening	$0	Deductible and Coinsurance
Diagnostic X-rays	$0	Deductible and Coinsurance
Lab Tests	$0	Deductible and Coinsurance
Mental Health Care (1) ■ Up to 60 outpatient visits in office or facility ■ Up to 90 professional visits per calendar year while in an inpatient facility	$25 Copayment per visit(2) $0(2)	Deductible and 50% Coinsurance
Chemotherapy & Radiation Therapy ■ Hospital outpatient ■ Physician's office	$0	Deductible and Coinsurance
Second Surgical Opinion	$0	Not Applicable
Ambulance	Not Applicable	$0, Not Subject to Deductible and Coinsurance
Allergy Testing and Treatment	$10 Copayment per visit $0 for testing fees and treatment visits	Deductible and Coinsurance
Diagnostic Screening Tests	$0	Deductible and Coinsurance

(1) Combined Maximum for In-Network and Out-of-Network services.
(2) Behavioral health care management program must pre-approve, except for providers outside the United States.

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BLUECHOICE® PPO BENEFITS SUMMARY		
MEDICAL BENEFITS (continued)	**In-Network MEMBER PAYS**	**Out-of-Network MEMBER PAYS**
Prosthetic & Orthotics, Durable Medical Equipment	$0	Deductible and Coinsurance
Medical Supplies	Not Applicable	$0, Not Subject to Deductible and Coinsurance
Private Duty Nursing (In the home only) $5,000 per year; $10,000 lifetime	Not Applicable	$0, Not Subject to Deductible and Coinsurance
Well Woman Care	$10 Copayment	Deductible and Coinsurance
Annual Physical Exam	$10 Copayment	Not Covered
Well Child Care (including recommended immunizations) ■ Newborn baby - 1 in-hospital exam at birth ■ Birth to 1 year of age - 6 visits ■ 1 through 2 years of age - 3 visits ■ 3 through 6 years of age - 4 visits ■ 7 years until 19th birthday - 6 visits	$0	Deductible and Coinsurance
Chiropractic Care ■ Up to 30 visits per calendar year	Plan pays $30 per visit; member pays the balance	
Prescription Drug Card Program	15% Copayment up to a Maximum of $15 per prescription; Mail Order with $10 Copayment	15% Coinsurance (Claim must be filed for reimbursement)
Hearing Aid	Not Applicable	One Exam every three years; (limit $100); one hearing aid per ear every three years (limit $600)
Vision Care	One Exam each 24 months with $5 Copayment; $10 Copayment for Frames; $35 allowance for non-plan eyewear	Not Covered
Physical Therapy ■ Up to 45 inpatient visits per calendar year(1) ■ Up to 30 visits combined in home, office, outpatient facility(1)	$0 in facility $10 Copayment (home or office)	Deductible and Coinsurance
Other Therapies (occupational, speech, hearing, vision) ■ Up to 30 visits combined in home, office, or outpatient facility (1)	$0 in facility $10 Copayment (home or office)	Deductible and Coinsurance
(1) Combined Maximum for In-Network and Out-of-Network services.		

Discount prescription drug programme (Empire Pharmacy Management)

1. With effect from 1 April 1997, the Blue Cross Empire Pharmacy Management (EPM) discount prescription drug programme has been administered by MedImpact. Replacement identification cards were distributed to all participants in connection with the change from the previous administrator of the programme.

2. The Empire Pharmacy Management (EPM) programme reimburses at significant savings prescription drugs obtained from participating pharmacies. Under this programme, a retail pharmacy network is provided by Empire Pharmacy Management through MedImpact as well as a mail order facility through Express Pharmacy Services.

3. Significant cost savings are being passed on to participants by utilizing either a participating pharmacy or the Express Pharmacy Services mail order facility. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a brand-name drug be dispensed by indicating "Dispense as written" or "DAW", a generic equivalent drug will be provided by the pharmacist, and the discount off the AWP will average 43 per cent depending on the generic equivalent supplied. The discount for maintenance drugs obtained through Express Pharmacy Services will range from 18 per cent to as high as 50 per cent off AWP, depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

4. The procedure under which prescription drugs is reimbursed through the Empire Pharmacy Management programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice ALONG WITH THE EMPIRE PHARMACY MANAGEMENT CARD (a listing of participating pharmacies in the New York metropolitan area may be found in annex VII). The pharmacist will fill the prescription for up to a 34-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) on the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

5. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through the Express Pharmacy Services mail order facility, which will charge a fixed $10 co-payment per prescription. The Express Pharmacy Services claim form supplied with the Empire Pharmacy Management card should be utilized for ordering maintenance drugs by mail. A new order form will be sent along with the filled prescription. The address and telephone number of the mail order prescription drug facility is as follows:

Express Pharmacy Services
P.O. Box 270
Pittsburgh, PA 15230-9949
Tel. No. (888) 624-5376

6. It should be noted that if a generic equivalent is available and a participant receives a brand-name drug at his or her request even though the physician has not specified a brand-name by indicating "Dispense as written" (DAW) on the prescription, the participating pharmacy and/or the Express Pharmacy Services mail order facility will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

7. As the Blue Cross BlueChoice prescription drug programme is being administered separately by Empire Pharmacy Management, the normal annual deductible under the BlueChoice plan will NOT be applied to prescription drugs. At the same time, however, prescription drug co-insurance will NOT count towards meeting the annual co-insurance limit of $900. Prescription drugs obtained outside the United States or within the United States but not through the Empire Pharmacy Management MedImpact's participating network will be reimbursed through the submission of a claim form to the claims office at the following address:

Empire BCbS (EPM)
Pharmacy Unit
P.O. Box 5099
Middletown, NY 10940-9099
Tel. No. (800) 839-8442

The special claim form to be utilized for this purpose is available in the offices of the Insurance, Claims and Compensation Section, room S-2765. Claims submitted to the claims office will not be subject to the annual deductible. However, a 15 per cent co-insurance will be assessed on the charges submitted and the $15 limit for each prescription will NOT apply. In addition, the 15 per cent co-insurance will not count towards meeting the annual co-insurance limit of $900.

Other provisions

1. Certain expenses are not covered under the BlueChoice plan. These comprise expenses for services or supplies not deemed by Blue Cross as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Blue Cross as reimbursable under the plan, Blue Cross should be contacted at (800) 377-5156 prior to commencement of treatment. In addition, the Blue Cross policy contract document is on file in the offices of the Insurance, Claims and Compensation Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

2. If Blue Cross denies a claim in whole or in part, the subscriber has the right to appeal the decision. Blue Cross will send written notice of the reason for he denial. The subscriber then has 60 days to submit a written request for review. Blue Cross will send a written decision with an explanation within

60 days of receiving the appeal. If special circumstance require more time, Blue Cross can extend the review period up to 120 days from the date the appeal was received. For a review of a hospital or medical claim, write to:

Empire Blue Cross and Blue Shield
P.O. Box 4606
New York, NY 10163-4606
Attention: Group Accounts

3. Subscribers should note that claims for reimbursement must be submitted to Blue Cross no later than two years from the date on which the medical expense was incurred. CLAIMS RECEIVED BY BLUE CROSS LATER THAN TWO YEARS AFTER THE DATE ON WHICH THE EXPENSE WAS INCURRED WILL NOT BE ELIGIBLE FOR REIMBURSEMENT.

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Annex III

HEALTH INSURANCE PLAN OF GREATER NEW YORK/HEALTH MAINTENANCE ORGANIZATION

Plan outline

The HIP/HMO plan follows the concept of total prepaid group practice hospital and medical care, i.e., there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area, including New Jersey and certain areas in Florida. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP/HMO participating pharmacies and are prescribed by HIP/HMO physicians or any physician in a covered emergency. HIP/HMO participants may select a physician at a HIP medical centre or from a new listing of neighbourhood affiliated physicians for primary care services. The affiliated physician is visited in his or her private office. Specialty care, however, will continue to be given in a HIP medical centre based upon the referral of the selected affiliated physician. To select a neighbourhood affiliated physician, the HIP participant should call HIP at (800) HIP-TALK. Additional information regarding this expansion of HIP providers will be provided to participants during the annual enrolment campaign and also mailed by HIP to all participants.

Premium

There will be a 4.0 per cent decrease in the total monthly premium of the HIP/HMO plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1997. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

Benefits under the HIP/HMO plan will remain unchanged in the renewal period.

HIP/HMO benefits summary

Type of benefit	HIP/HMO coverage
Hospital services	Covered in full when authorized by HIP/HMO physician

Type of benefit	HIP/HMO coverage
In-hospital physician's services	Covered in full if rendered by HIP/HMO physician
Private duty nursing	Covered in full when authorized by HIP/HMO physician or by any physician in a covered emergency
Skilled nursing facility	No limit on number of days when care is in lieu of hospitalization. Care must be arranged by HIP/HMO physician
Visits to physician's office/ health centre	Covered in full at any HIP/HMO medical centre or if care is rendered by HIP/HMO physician
House calls	Covered in full when authorized by HIP/HMO physician or emergency service programme
Maternity care	No waiting periods. Covered in full when care is rendered by HIP/HMO physician. Prenatal, postnatal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP/HMO physician. Eye examinations are covered in full when rendered by a HIP/HMO physician (eyeglasses and hearing aids are excluded)
Mental health services:	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders
Out-patient	HIP/HMO has its own mental health centres that provide psychotherapy and counselling for adults and children with mental or emotional problems. Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded

Type of benefit	HIP/HMO coverage
Alcoholism and substance abuse:	
In-patient	Covered in full for up to 30 days in any calendar year in a state-certified alcoholism or substance-abuse treatment facility
Out-patient	Medical services for diagnosis and treatment of alcoholism or substance abuse for a period not to exceed 60 visits in any calendar year. HIP/HMO mental health centres will be used for the out-patient services
Emergency services:	
In-area	HIP/HMO has an emergency service programme that is in operation when your medical group is closed. This provides the HIP/HMO subscriber with a 24-hour, 7-day service
Out-of-area	Hospital service: In-patient - covered in full; Out-patient - covered in full, when care is received within 12 hours of onset of illness or within 72 hours (three days) following injury. Doctor services - HIP/HMO pays customary and reasonable non-HIP/HMO physician fees for covered emergency illness or accidental injury
Prescription drugs and medical appliances	$5 co-payment for prescription drugs, but not appliances, when obtained through HIP/HMO participating pharmacies. The drugs and appliances must be prescribed by HIP/HMO physicians, or any physician in a covered emergency
Preventive dental care	Annual cleaning and other preventive dental services performed by a HIP dentist. $5 co-payment per service
Grievance procedure	Refer to member handbook sent to subscribers

Annex IV

KAISER FOUNDATION HEALTH PLAN OF THE NORTHEAST/HEALTH MAINTENANCE ORGANIZATION

Plan outline

The Kaiser Foundation Health Plan is an HMO, providing all medical-related services at Kaiser medical group centres or network affiliates. Services under this plan are accessible to staff members residing in northern Bronx, Westchester County and southern Connecticut. Kaiser health centres accommodate not only physicians' offices but also laboratory, X-ray, pharmacy and mental health services. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. There is no ceiling on the use of authorized services, no deductibles to cover and no insurance forms to complete. The plan coverage emphasizes early detection of medical problems before they become major illnesses.

Premium

There will be a 3.5 per cent increase in the total monthly premium of the Kaiser/HMO plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1997. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

Benefits under the Kaiser/HMO plan will remain unchanged in the renewal period.

Kaiser/HMO benefits summary

Type of benefit	Kaiser/HMO coverage
Hospital services	Covered in full when authorized by a Kaiser physician
In-hospital rehabilitation	60 days of in-patient rehabilitation care per condition provided in a hospital or skilled nursing facility
In-hospital physician's services	Covered in full if rendered or authorized by a Kaiser physician

Type of benefit	Kaiser/HMO coverage
Private duty nursing	Covered in full when considered medically necessary
Skilled nursing facility	Covered in full for 100 days per contract year when prescribed, arranged and approved by a Kaiser physician
Visits to physicians' office/health centre	Covered in full at any Kaiser medical centre nationwide or if rendered by or referred by a Kaiser physician
House calls	Covered in full for a registered nurse or Kaiser physician when medically necessary. Limited to the service area
Maternity care	No waiting period. Covered in full when rendered by a Kaiser physician. Prenatal, postnatal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens, twice yearly preventive dental care	Covered in full when rendered or authorized by a Kaiser physician. Preventive dental care for children under 12 years of age only
Alcoholism treatment:	
In-patient	Covered in full for detoxification only
Out-patient	Covered in full up to 60 out-patient visits per calendar year for the diagnosis and treatment of alcoholism
Mental health services:	
In-patient	Covered in full for 30 days per contract year
Out-patient	Covered in full at Kaiser Medical Center for short-term evaluation or crisis intervention for visits 1-10 per contract year. Visits 11-20 are covered subject to a 25 per cent co-insurance of the Kaiser fee-for-service rate. Visits 21-30 are covered at 50 per cent of the Kaiser fee-for-service rate

Type of benefit	Kaiser/HMO coverage
Emergency services:	
$25 co-payment	A $25 co-payment will be assessed for emergency care services. Immediate notification to Kaiser required if admitted to a hospital (or within a reasonable period of time if incapacitated). Out-patient emergency care requires 48-hour notification to Kaiser, i.e., within 48 hours after the care is received
In-area	Covered in full for life-threatening conditions for care received in a hospital emergency room. Kaiser must be notified first, if possible, or, if not possible, within 48 hours of treatment
Out-of-area	Covered in full for reasonable charges for sudden onset of an illness or accident requiring immediate attention. Kaiser must be notified within 48 hours
Prescription drugs and medical appliances	$3 co-payment for all prescriptions prescribed by Kaiser physicians and obtained at Kaiser pharmacies. Durable medical equipment is covered in full. Coverage is provided for internal prosthetic devices and for their replacement
Grievance procedure	Refer to member handbook sent to subscribers

Annex V

GROUP HEALTH INCORPORATED (PREFERRED) DENTAL PLAN

Plan outline

The GHI "Preferred" Dental plan is a defined benefit scheme, i.e., benefits are paid in accordance with an established schedule of allowances for a wide range of dental procedures. While the schedule of benefits available under the GHI "Preferred" Dental plan may be utilized to offset the costs of dental services provided by independent (fee-for-service) practitioners, staff members are encouraged to make maximum use of the dental practitioners who participate in the GHI Dental plan.

GHI participating (or network) providers, in most cases, accept the "Preferred" schedule of allowances as payment in full for services rendered. The plan involves no deductible and no co-payment on the part of the subscriber. Thus, treatment by a participating GHI provider will, in most cases, involve no financial outlay by the subscriber.

GHI directory of participating providers

A complete directory listing GHI participating dental providers in the greater New York metropolitan area is available in the offices of the Insurance, Claims and Compensation Section, room S-2765. Copies of the updated directory will be available from 1 July 1997.

Premium

There will no increase in the total monthly premium of the GHI Dental plan (shared between the staff member and the Organization) for the renewal period commencing 1 July 1997. The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

The benefits under the GHI "Preferred" Dental plan will remain unchanged for the renewal period.

GHI dental benefits summary

THERE IS A CALENDAR YEAR BENEFIT MAXIMUM OF $2,000.

	Maximum allowance $
EXAMINATIONS	
Periodic	15
Initial	20
Emergency	15
PROPHYLAXES (cleaning)	
Two per calendar year	
Under 12 years	20
12 years and over	30
ORAL SURGERY - EXTRACTIONS	
Impaction - Complete bone	150
Soft tissue	100
Partial bone	125
Extraction - Difficult	50
Routine	30
RESTORATIONS (FILLINGS)	
Amalgam - One surface	30
Two surfaces	40
Three surfaces	50
Reinforcement pin, maximum one per tooth	15
Synthetic porcelain composite - Per filling	30
Two fillings	45
Maximum per tooth	50
Molar, open reduction, depressed compound	300
Tooth reimplantation caused by trauma due to forces outside the mouth	50
Temporo-mandibular joint (TMJ), closed reduction	75
Acrylic/three fillings, maximum per tooth	N/A
Composite fillings	35
Two fillings	45
Three fillings, maximum per tooth	50
Temporary fillings	None

	Maximum allowance $
ORAL SURGERY - OTHER	
Maxilla, open reduction - Simple	300
Compound	450
Mandible, closed reduction - Simple	350
Compound	350
Mandible, open reduction, compound	450
Molar, closed reduction, simple	100
TMJ, closed reduction with wiring	150
Incision and drainage of periodontal abscess	25
Cyst removal	75
Incision and drainage of abscess	35
Biopsy and examination of oral tissue	35
Biopsy report	20
Closure of oral antral fistula	100
Removal - Labial frenum	100
Lingual frenum	100
Alveolectomy, upper jaw with extractions - Per tooth	10
Maximum upper	100
Alveolectomy, lower jaw with extractions - Per tooth	10
Maximum lower	100
Alveolectomy without extractions, per quadrant - Upper jaw	100
Lower jaw	100
ORTHODONTICS	
(Benefits are available only to eligible children to the end of the calendar year in which they reach age 19.)	
Removal - Preliminary acrylic	75
Metal appliance	75
Fixed or cemented - Acrylic	75
Metal	75
Diagnosis, construction and insertion of orthodontic appliance	300
Active orthodontic treatment (next 20 months)	67
Lifetime maximum allowance	1 340
Six months passive treatment	36
Maximum allowance (18 months)	108
EMERGENCY TREATMENT	
Emergency visit for relief of pain	15

	Maximum allowance $
PERIODONTICS	
Periodontal treatment	40
Maximum allowance each calendar year	200
Gingivectomy, five-teeth area	135
Osseous surgery, per quadrant	250
PROSTHETIC SERVICES	
Immediate full denture - Upper	400
Lower	400
Permanent full denture - Upper	400
Lower	400
Acrylic partial denture, 2 + clasps and rests - Upper	285
Lower	285
Cast partial denture, 2 + clasps and attachment - Upper	425
Lower	425
Cast partial denture, 2 + clasps, no attachment - Upper	425
Lower	425
Unilateral partial (Nesbitt) - One tooth	145
Two teeth	160
Three teeth	160
Add tooth to partial denture - First tooth	50
Additional teeth, per tooth	20
Adding new clasp to existing partial	54
Obturator, not including denture	200
Rebase or reline (R/R) lab processed	
Full denture - Upper	130
Lower	130
Partial denture - Upper	130
Lower	130
Denture, chairside - Full upper	90
Full lower	90
Partial upper	75
Partial lower	75
Duplicating partial - Upper jaw	160
Lower jaw	160
Pontic - Cast metal or acrylic	175
Porcelain fused to metal	200
Porcelain veneer abutment crown	375
Acrylic veneer abutment crown	325
Full cast abutment crown in 3 + unit bridge	300
3/4 cast abutment crown in 3 + unit bridge	215
Maryland bridge retainer	135

	Maximum allowance $
Inlay - Two-surface metallic abutment in 3 + unit bridge	150
Three-surface metallic abutment	200
Metal post with or without coping	95
Crown - 3/4 cast	215
Full cast	300
Full cast with acrylic veneer	325
Full cast with porcelain veneer	375
Inlay - Two surfaces - metallic	125
Three surfaces - metallic	150
Porcelain jacket crown	225
Acrylic/vinyl jacket crown, lab-processed	125
Crown - Steel shell	60
PROSTHETIC REPAIR	
Repair broken denture with or without broken teeth	45
Replace broken teeth in broken denture, per tooth	28
Repair broken teeth in denture not requiring other repairs	
First tooth	50
Each additional tooth	25
New clasp/replacing broken clasp	75
Reattach undamaged clasp	40
Replacing facing on pontic or crown	40
Recementing fixed bridge - single inlay, crown or facing	20
Two or more abutments	30
Maximum repairs per family member per calendar year	110
ENDODONTICS	
Root canal therapy (RCT) - One canal filled	175
Two canals filled	225
Three canals filled	275
Pulpotomy	50
Apicoectomy, single procedure	140
Apicoectomy, including RCT and/or root-end amalgam	245
Each additional canal	50
MISCELLANEOUS	
Fluoride treatment - Stannous	15
Anaesthesia in-hospital, each 15 minutes of anaesthesia	24
Consultation with dental specialist	35
Professional visit to bedside	20
Mouth guard for athletic purposes - removable acrylic	50
Space maintainer - Fixed band type, lingualar palatal arch	100
Fixed, unilateral band type	75

	Maximum allowance $
RADIOLOGY	
PA X-ray - Initial	3
Each additional	3
Full mouth series, maximum one every three years	30
Intra-oral films, occlusal view for endentulous jaws, maxillary or mandibular, single film, two every three years	10
Bite-wing X-ray - Initial	6
Each additional film	6
Maximum four each calendar year	24
Antero-posterior head and jaw, single film	25
Lateral X-ray, head and jaw, single film	25
Temporo-mandibular joint (TMJ), single film	25
Cephalometric X-ray	25
Panoramic, one series every three years	30

PRE-DETERMINATION AMOUNT

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with GHI before the course of treatment begins. The dentist should be sure to include the American Dental Association (ADA) procedure code for each procedure claimed.

Grievance procedure

If a subscriber disagrees with the disposition of a claim by GHI, a review may be requested. Such request must be made in writing to GHI (Attention: Claims Appeals) within 60 days of notification. The subscriber's GHI certificate number and the claim number concerned, as well as any pertinent information regarding the disputed claim, should be included in the request for review. Upon receipt of the request for review, the claim will then be reconsidered, taking into account such additional information as may have been provided by the subscriber. Upon completion of this review, the subscriber will receive written notification of the decision, explaining the upholding or modification of the original disposition of the claim.

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Annex VI

WORLD ACCESS

World Access (formerly known as Access America) is a facility available to Aetna and BlueChoice subscribers. The $0.25 per month per subscriber cost of the World Access facility is built into the premium schedule for Aetna and BlueChoice set out on page 2 of the present circular.

World Access provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad, or within the United States, when at least 100 miles from one's normal place of residence. Participants who call the hotline numbers below will, where possible, be provided with referrals from a worldwide network of physicians, dentists, hospitals, pharmacies and other medical facilities. In addition, in most cases, World Access will settle the costs of EMERGENCY foreign hospital admission and treatment. If the emergency hospitalization occurs in the United States and the hospital does not accept the Aetna or the Blue Cross BlueChoice identification cards, World Access will also settle the related costs directly with the hospital and then claim reimbursement directly from Aetna or Blue Cross as the case may be. In the case of hospitalization, World Access medical staff will contact the insured patient's local physician in order to monitor the case and services being received. In the event of an emergency hospitalization in the circumstances described above, it is important that World Access be contacted upon admission to the hospital or, at the latest, before discharge. It should also be emphasized that any hospital bill paid by the participant must be sent to Aetna for reimbursement or Blue Cross, as World Access does not reimburse participants directly.

The hotline numbers are:

(800) 654-1901 - (in the United States, Canada, Puerto Rico and the Virgin Islands)

(804) 673-1159 - collect (from Alaska, Washington, D.C. and all other locations), or

Fax No. (804) 673-1179

When contacting World Access, be sure to identify yourself as a United Nations participant. Please state the World Access identification number for the United Nations, which is 2065. In addition, you are reminded that your Aetna and Blue Cross BlueChoice subscriber identification number is:

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Annex VII

AETNA AND BLUE CROSS PLANS
LIST OF PARTICIPATING PHARMACIES

Set out below are lists of the major participating chain pharmacies under the Aetna and Blue Cross discount prescription drug programmes. The Aetna and Blue Cross directories of participating pharmacies are available at the offices of the United Nations Insurance, Claims and Compensation Section; the Division of Personnel, UNDP; and the Office of Personnel, UNICEF. In addition, if a participating pharmacy is needed while traveling, referral information is available from Aetna ((800) 238-6279) and Blue Cross ((800) 839-8442).

Aetna Participating Chain Pharmacies

New York	New Jersey	Connecticut
AARP Phcy Service	ACME Phcy	AARP Phcy Service
A & P Phcy	A & P Phcy	A & P Phcy
Brooks Drug	Brooks Drug	Arrow Prescription Ctr
Caldor Phcy	Caldor Phcy	Arthur Drug Stores
Costco Phcy	Clover Phcy	Brooks Drug
CVS	Costco Phcy	Caldor Phcy
Drug Mart	CRX Phcy	Costco Phcy
Drug World	CVS	CVS
Duane Reade	Drug Fair	Douglas Drug
Edwards Phcy	Drug World	Edwards Phcy
Fay's	Duane Reade	F & M Distributors
Finast Phcy	Eckerd Drugs	Genovese
Freddy's	Food Town Phcy	Grand Union Phcy
Genovese	Foodmax Phcy	K Mart Phcy
Grand Union Phcy	Genovese	The Medicine Shoppe
Great American Drug	Grand Union Phcy	NPSC/EPIC
K Mart Phcy	Happy Harry's	Pathmark Phcy
King Kullen Phcy	K Mart Phcy	Purity Phcy
Kinney Drugs	The Medicine Shoppe	Rite Aid
Leroy Phcy	Pathmark Phcy	Shop Rite Phcy
The Medicine Shoppe	Phar-Mor	Super X Drug Store
Pathmark Phcy	Pharmhouse	The RX Place
Peterson Drug Co.	Quick Check	Shop & Stop
Phar-Mor	Revco	Waldbaum's Phcy
Pharmhouse	Rite Aid	Walgreens
Price Chopper Phcy	RXD Phcy	Wal-Mart
Revco	Sav-On	Woolworth Phcy
Rite Aid	Shop Rite Phcy	
Rockbottom Phcy	Super X Drug Store	
Shop'N Save Phcy	The RX Place	
Shop Rite Phcy	Thrift Drug	
The RX Place	Thrift RX	
Shop & Stop	Waldbaum's Phcy	
Thrift Drug	Walgreens	
Tops Phcy	Wal-Mart	
Vix Phcy	Woolworth Phcy	
Waldbaum's Phcy		
Walgreens		
Wal-Mart		
Wegmans Phcy		
Weis Phcy		
Woolworth Phcy		

Blue Cross Participating Chain Pharmacies

A & P
Brooks Phcy
Costco
CVS
Drug Mart
Duane Reade
Eckerd
Edwards
Finast
Foodtown
Freddy's
Genovese
Grand Union
JC Penney Prescription Ctr
K Mart
Phar-Mor
Pharmhouse
Price Chopper
Price Club
Revco
Rite Aid
Safeway
Sav-On
Shop'N Save
Shoprite
SupeRx
Target
The Medicine Shoppe
Thrift Drug Store
Tick Tock Drugs
Tops
Vons
Wal-Mart
Waldbaum's
Walgreens
Weis

Annex VIII

INSURANCE CARRIER ADDRESSES AND TELEPHONE NUMBERS FOR CLAIMS AND BENEFIT INQUIRIES

I.	AETNA OPEN CHOICE PLAN (medical and out-of-network pharmacy claims)	Aetna Life Insurance Company Unit 73 3541 Winchester Road Allentown, PA 18195-0501
	Tel.: (800) 784-3991	Member Services (benefit/claim questions)
	Tel.: (800) 238-6279	Participating pharmacy referral
	Tel.: (800) 999-2655	Walgreen's Customer Service (mail order drugs)
	Tel.: (800) 749-0009	Maintenance drug automated refills (by credit card)
	Tel.: (800) 424-1601	Focused Psychiatric Review (FPR)
	Tel.: (800) 793-8616	Vision One
II.	BLUE CROSS BLUECHOICE PLAN	Empire Blue Cross 622 Third Avenue New York, NY 10017
	Tel.: (800) 377-5156	Member Services (benefit/claim questions)
	Tel.: (800) 982-8089	Utilization Management Program (pre-certification for hospital admissions, elective surgery, home care, skilled nursing facilities and second opinion referrals
	Tel.: (800) 626-3643	Behavioral Health Care Management Program (prior approval of mental health/substance abuse care
	Tel.: (888) 624-5376	Express Pharmacy Services, Inc. (maintenance drug mail order)
	Tel.: (800) 839-8442	Empire Pharmacy Management Programme/MedImpact (prescription card programme and pharmacy network information)
III.	HIP/HMO Tel.: (800) HIP-TALK ((800) 447-8255)	HIP Member Services Department 7 West 34th Street New York, NY 10001
IV.	KAISER/HMO Tel.: (914) 682-6500	Kaiser Foundation Health Plan 210 Westchester Avenue White Plains, NY 10604
V.	GHI DENTAL PLAN Tel.: (212) 501-4443 (claim questions and participating provider referrals)	Group Health Incorporated (GHI) P.O. Box 1701 New York, NY 10023 Attention: Dental Correspondence Unit

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